

# Mountain River Physical Therapy

## New Patient Referral

Please **FAX** to the following numbers for the clinic requested.

<b>Parkersburg</b>	304-865-7400	<b>Wheeling</b>	304-230-5603
<b>Vienna</b>	304-865-6780	<b>New Martinsville</b>	304-447-6779
<b>Mineral Wells</b>	304-489-8191	<b>Wellsburg</b>	304-737-0581
<b>Ellenboro</b>	304-869-3444	<b>Leesport, PA</b>	610-926-7200
<b>Elite Sports Center</b>	304-422-1176	<b>Athens, OH</b>	740-593-7481

### Referring Physician

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
NPI # \_\_\_\_\_

### Patient

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell \_\_\_\_\_  
Birth Date \_\_\_\_\_  
SSN \_\_\_\_\_

### Diagnosis (Please include a prescription for physical therapy)

Dx code \_\_\_\_\_  
Other Comments \_\_\_\_\_

### Insurance (Please include a copy of current insurance card)

Insurance Company Name \_\_\_\_\_  
Cardholder Name \_\_\_\_\_  
Policy # \_\_\_\_\_

### Auto Accident?      Yes    No      Workers Comp?      Yes    No

Date of Injury \_\_\_\_\_  
Claim # \_\_\_\_\_  
Claim Manager \_\_\_\_\_  
Approved Dx \_\_\_\_\_